Nationwide Health Systems Davao, Inc.

FILL UP WITHIN THE DOTTED AREA:

DATE:_____ **TI:**_____ **TO:**_____

HAP/IME/NZER #:_____

PRIORITY NO.

_____

NOTES:

☐ Australia ☐ Permanent ☐ Dependent_____ ☐ Student_____
☐ Canada ☐ Temporary ☐ Working ☐ Tourist (Date Intake)
☐ New Zealand ☐Full Medical ☐ Limited Medical Course Abroad:_____
Furtherance ☐ TB ☐ Non TB_____ Work Abroad:_____

Passport Number:_____ **Date Issued:** _____ **Expiration:** _____

☐ **No Passport** **Other VALID ID #:** _____

Last Name:_____ ***Age:***_____ ***Sex:*** ☐ **F** ☐ **M**

First Name:_____ ***Date of Birth:*** _____

Middle Name: _____ ***Civil Status:*** ☐ **S** ☐ **M** ☐ **W** ☐ **S/D**

Address:_____ **Occupation:**_____

Email Address:_____

CP #: 1._____

2._____

***Only for women of reproductive age (12-50y/o):**

PREGNANT: ☐ **YES** ☐ **NO**

Last Menstruation Period: _____

COVID 19 VACCINE

VACCINE DATE	VACCINE BRAND
1ST DOSE:_____	1ST DOSE:_____
2ND DOSE:_____	2ND DOSE:_____
BOOSTER 1ST::_____	BOOSTER 1ST::_____
BOOSTER 2ND :_____	BOOSTER 2ND :_____

MEDICAL EXAM FLOW

- ☐ I. REGISTRATION/FRONT DESK
- ☐ II. PRE EXAM
- ☐ III. EMED REGISTRATION
- ☐ IV. CHEST X-RAY
- ☐ V. CASHIER
- ☐ VI. VITAL SIGN/NURSE AREA
- ☐ VII. PANEL PHYSICIAN (PE)
- ☐ VIII. BLOOD TEST
- ☐ XI. DISCHARGE/FINAL INSTRUCTED

H:_____ ***W:***_____ ***HC:***_____
BP1:_____ ***BP2:***_____
BP3:_____
*VA: L:*_____ *R:*_____
ROR ☐ *Present* ☐ *Absent*
TEMPERATURE:

MEDICATIONS

1.
2.
3.
4.
5.

DECLARATION BY EXAM

☐ I declare that this is my first time to have Immigration Medical Examination (IME).
☐ I had my last Medical on (date) _____ at _____.
☐ I declare that the information given above is TRUE and CORRECT

_____

Signature of Applicant over Printed Name
(If minor, Guardian can sign in behalf of the Applicant)

LABORATORIES
☐ PE ☐ HCV
☐ Urinalysis ☐Serum Crea
☐ Chest Xray PA/PA ☐ Hb1Ac
☐ HIV ☐CBC
☐ VDRL ☐ Chest ALV
☐ Hbsag ☐ Chest Spot

U/A #_____

DS	M1	M 2
☐ N	☐ N	☐ N
☐ AB	☐ AB	☐ AB
____	____	____

ADDITIONAL LABORATORY TEST
☐ Serum Creatinine ☐ ECG
☐ HBsag ☐ Ferritin
☐ Repeat Urinalysis ☐ **TST**_____
☐ Repeat CBC ☐ IGRA
☐ Other Test:_____

SPECIAL'S REPORT
☐ CARDIOLOGIST ☐ PEDIATRICIAN
☐ ENDOCRINOLOGIST ☐ OBYGNE
☐ NEPHROLOGIST ☐ OTHERS_____
☐ GASTROENTEROLOGIST
☐ PULMONOLOGIST

PATIENT'S HX
☐ **Exposure to TB**
☐ Household/Relative/YR
☐ History of PTB/ YR_____
☐ History of Primary Complex
☐ **Immunization MMR POLIO**
☐ **HX of travel Abroad**_____
☐ **HX of Autism/ ADHD**
☐ **CANCER/YR**_____
☐ **HX of Hosp**
☐ **HPN-YR**_____ **Admitted**___
☐ **DM-YR**_____

CHEST X-ray Result
☐ **Normal** ☐ **Abnormal**
_____
_____
_____
_____

Physical Examination
☐ **Normal** ☐ **Abnormal**
_____
_____
_____

☐ History of AB CXR Findings/Yr_____
☐ With previous CXR Images/YR_____
Previous CXR _____ ☐ Normal ☐ Abnormal
(Last 6months) Year
History of Chest Clinic Investigation:
- Year ___
- Tx/Duration _____ ☐DOTS ☐PRIVATE
- SPUTUM EXAM: ☐POSITIVE ☐NEGATIVE

GRADING & RECOMMENDATION

☐ **A** _____
☐ **B** _____
_____
_____
_____

PE FINDINGS
☐ CLAD
☐ AB LUNG FINDINGS
☐ DEV NOT AT PAR W/ AGE
_____

NOTES:

_____
_____
_____
_____

☐ **Checked By:** ☐ ***MD*** ☐ ***ML***
☐**Submitted Date:**

Panel Physician's Name
☐ NA ☐ CC ☐ *CD*
☐ GS ☐ CB ☐ *KC*